

# Integrated Dual Disorder Treatment: An Evidence Based Model for Treating Co-Occurring Severe Mental Illness & Substance Use Disorders

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# What Are Evidence-Based Practices?

- Standardized treatments
- Controlled research
- Objective outcome measures
- More than one research group
  - demonstrated effectiveness in helping consumers to achieve good outcomes in several different research trials

# Schizophrenia PORT Data

- Appropriate maintenance dose of antipsychotic: 29%
- Family psycho-education: 10%
- Vocational rehabilitation: 22%

# The Evidence-Based Practitioner Model



# What are dual disorders?

- Mental illness and substance abuse occurring together in one person



# Why focus on dual disorders?

- Substance use disorders are common in people with severe mental illness
- Mental illness is common in people with substance use disorders
- Dual disorders lead to worse outcomes and higher costs than single disorders

# Prevalence and Incidence of Dual Disorders

- In 2003, an estimated 4.2 million adult Americans met criteria for both severe mental illness (SMI) and substance dependence or abuse in the prior year
- 25-35% of people with SMI have an active substance abuse problem.
- Substance abuse among people with SMI has greater than three times the incidence as those in the general population
- About 50% of the people with severe mental illness will have a lifetime substance abuse disorder
- Substance Abuse and Mental Health Services Administration. (2005). *Overview of the findings from National Household Survey on Drug Use and Health*. (Office of Applied Studies, NSDUH Series H-27, DHHS Publication No. 05-4061). Rockville, MD.

# Integrated Dual Diagnosis Treatment Implementation

- Clinical focus on treatment for persons with severe and persistent mental illness and substance use disorder
  - Psychotic disorders
  - Bipolar disorders
  - Other severely disabling disorders

# IDDT Treatment Quadrants

**Low to Moderate  
Psychiatric Disorders**

*Low to Moderate  
Severity Substance Use  
Disorder*

**Low to Moderate  
Psychiatric Disorders**

*High Severity Substance  
Use Disorder*

**High Severity  
Psychiatric Disorders**

*Low to Moderate  
Severity Substance Use  
Disorder*


**High Severity  
Psychiatric Disorders**

*High Severity Substance  
Use Disorder*

# Course of dual disorders

- Both substance use disorders and severe mental illness are chronic, waxing and waning
- Recovery from mental illness or substance abuse occurs in stages over time
  - Precontemplation
  - Contemplation
  - Preparation
  - Action
  - Relapse prevention
    - Prochaska and DiClemente, Miller and Rollnick 1991

# Dual disorders lead to worse outcomes than single disorders

- Relapse of mental illness
  - Treatment problems and hospitalization
  - Violence, victimization, and suicidal behavior
  - Homelessness and Incarceration
  - Medical problems, HIV & Hepatitis risk behaviors and infection
  - Family problems
  - Increase service use and cost
- 

# Traditional treatment

- Treat each disorder separately
  - May be parallel or sequential
- Separate treatment is less effective


# Traditional treatment

- People with SPMI lack genuine access to AOD programs
  - Not admitted
  - Prematurely discharged
- People with AOD issues lack genuine access to MH programs
  - Not screened, assessed or diagnosed properly
- Implication that the consumer was a failure, not the treatment

# Rationale For Integrated Treatment

- 50% clients have substance use disorders
- Substance abuse worsens most outcomes:
  - hospitalization, incarceration, violence, victimization, homelessness, family disruptions, HIV, etc.
- Parallel treatment is ineffective

# Problems With Separate Mental Illness And Substance Abuse Treatments

- Different eligibility requirements
  - Trouble accessing both services
  - Primary/secondary distinction
  - Different treatment approaches
  - Lack of integration
- 

# Integrated dual disorders treatment: What is it?

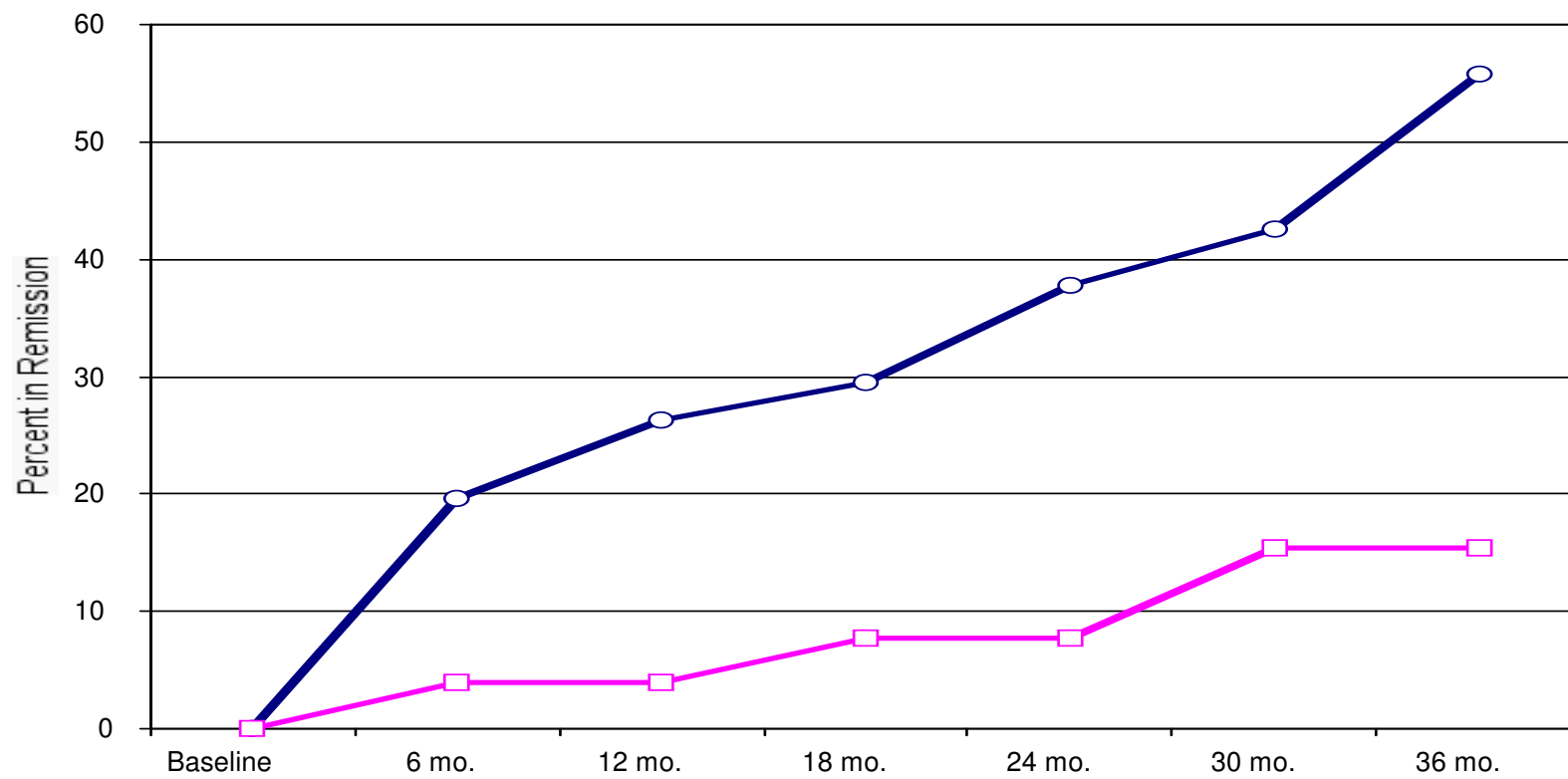
- Treatment of substance use disorder and mental illness together
  - Same team
  - Same location
  - Same time
  - Other characteristics to be described later

# Why integrated treatment of dual disorders?

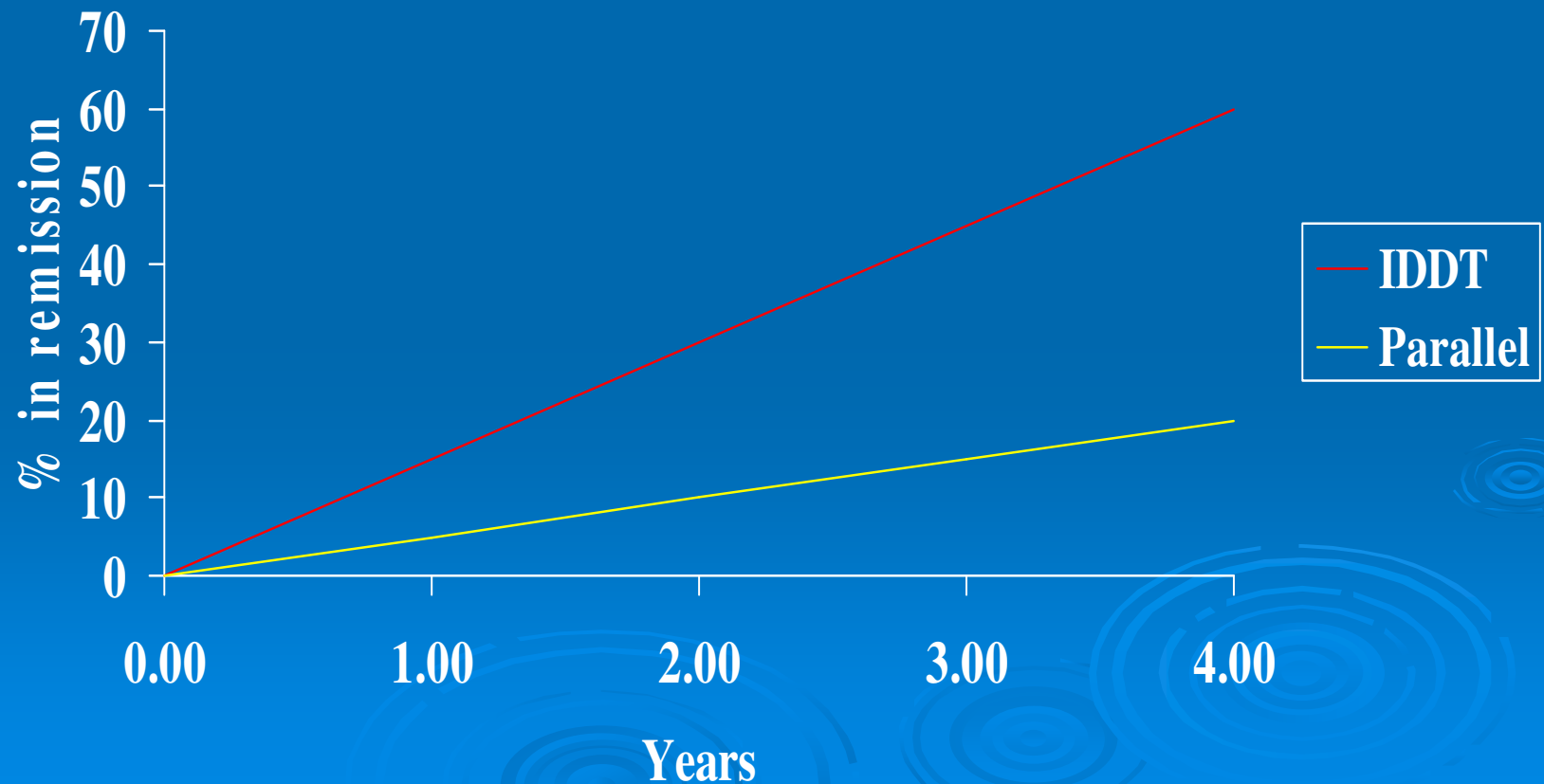
- More effective than separate treatment
- 26 studies show integrated treatment is more effective than traditional separate treatment
  - (Drake et al, Schiz Bull 1998 and Drake et al, Psych Services 2001, Psych Rehab Jrnl. 2004 for summaries).

# Fidelity to IDDT principles improves abstinence

Figure 1. Percent of Participants in Stable Remission for High-Fidelity ACT Programs (E ; n=61) vs. Low-Fidelity ACT Programs (G ; n=26).




# Abstinence after Integrated Dual Disorder Treatment



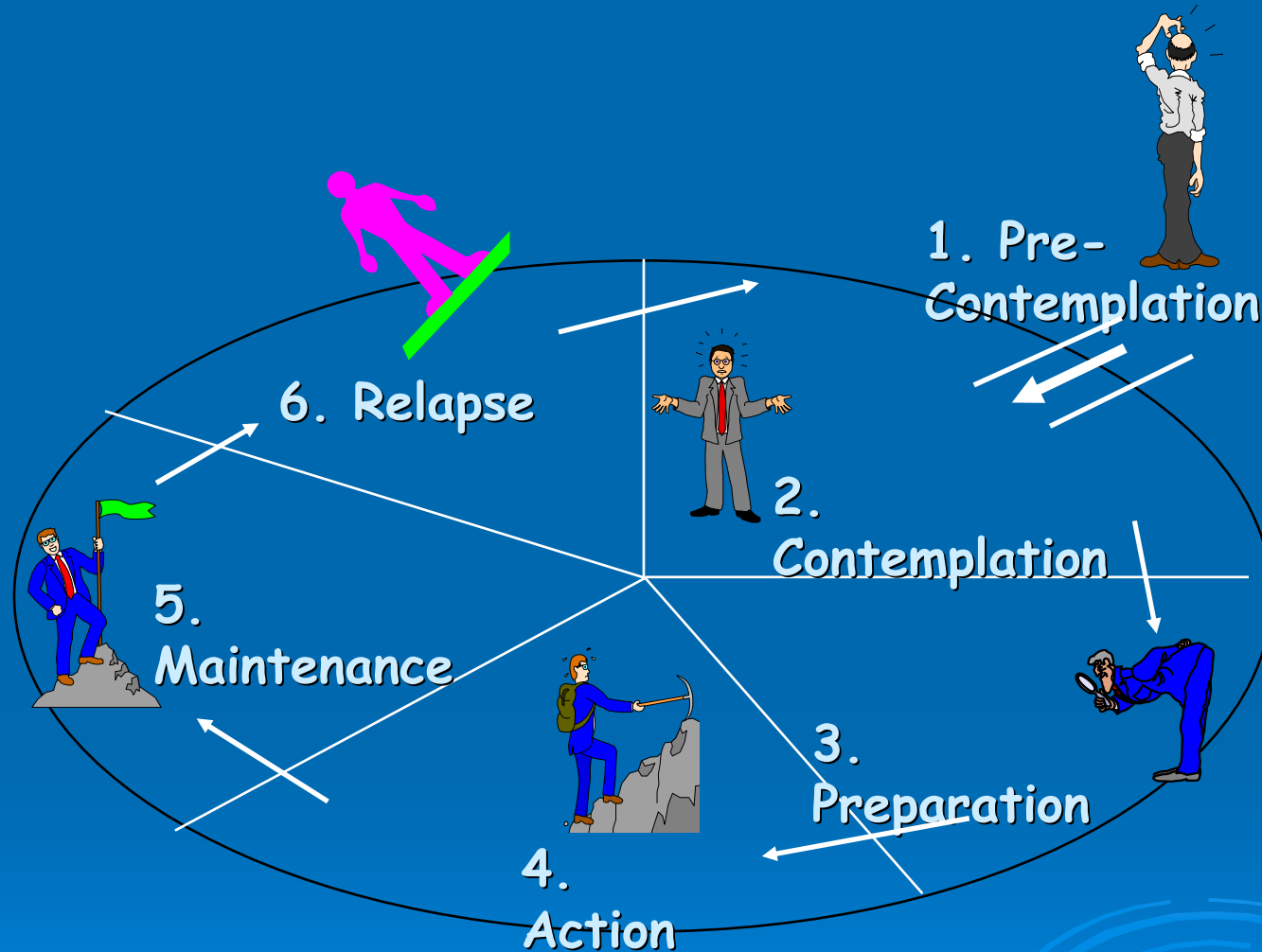
# Abstinence leads to improvements in other outcomes

- Reduce institutionalization
- Reduce symptoms, suicide
- Reduce violence, victimization, legal problems
- Better physical health
- Improve function, work
- Improve relationships and family

# Treatment factors for recovery

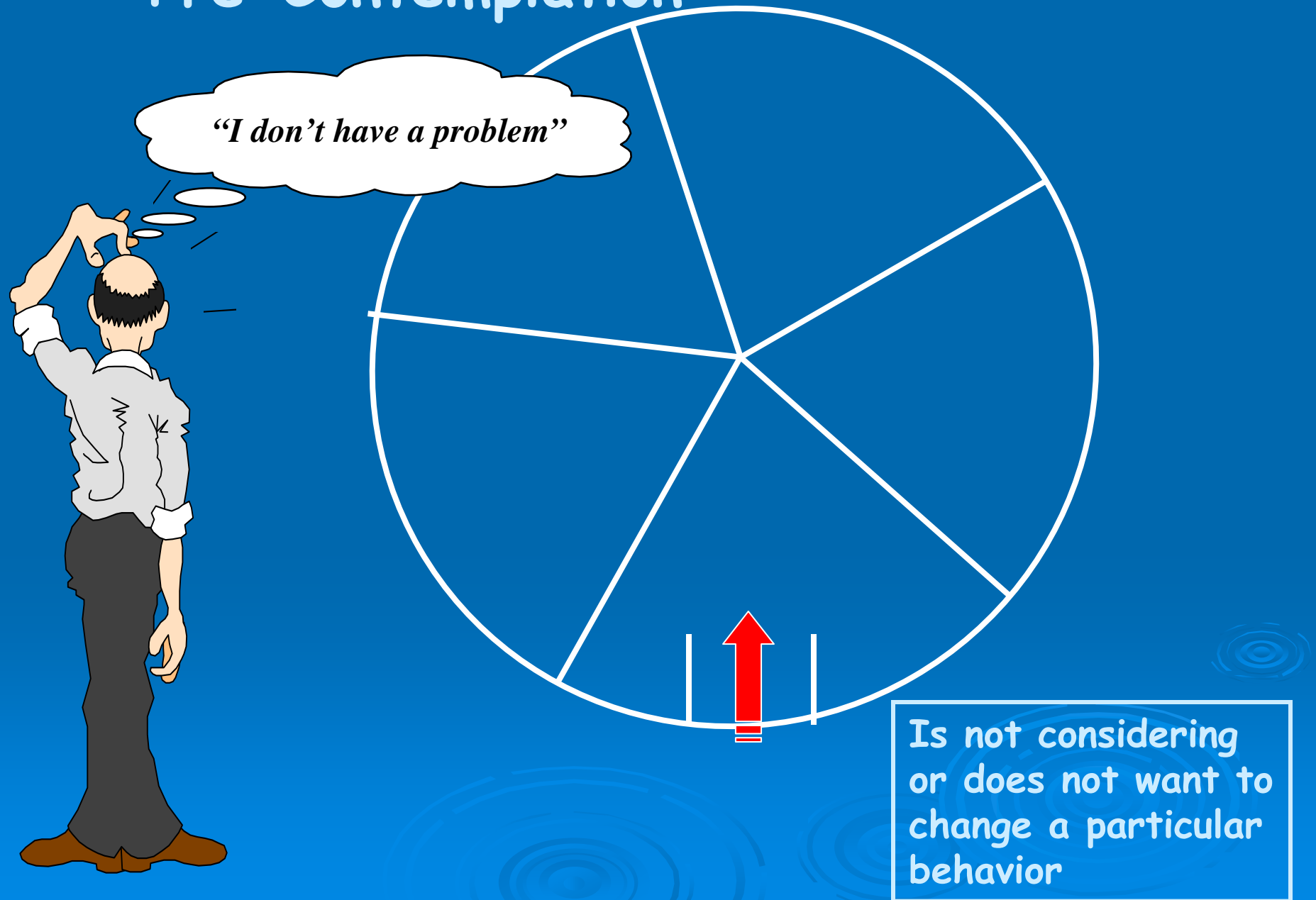
- Integration of mental health and substance abuse treatment
  - Stage-wise interventions
  - Assertive outreach
  - Motivational counseling
  - Substance abuse counseling
- 

# STAGES OF CHANGE -When



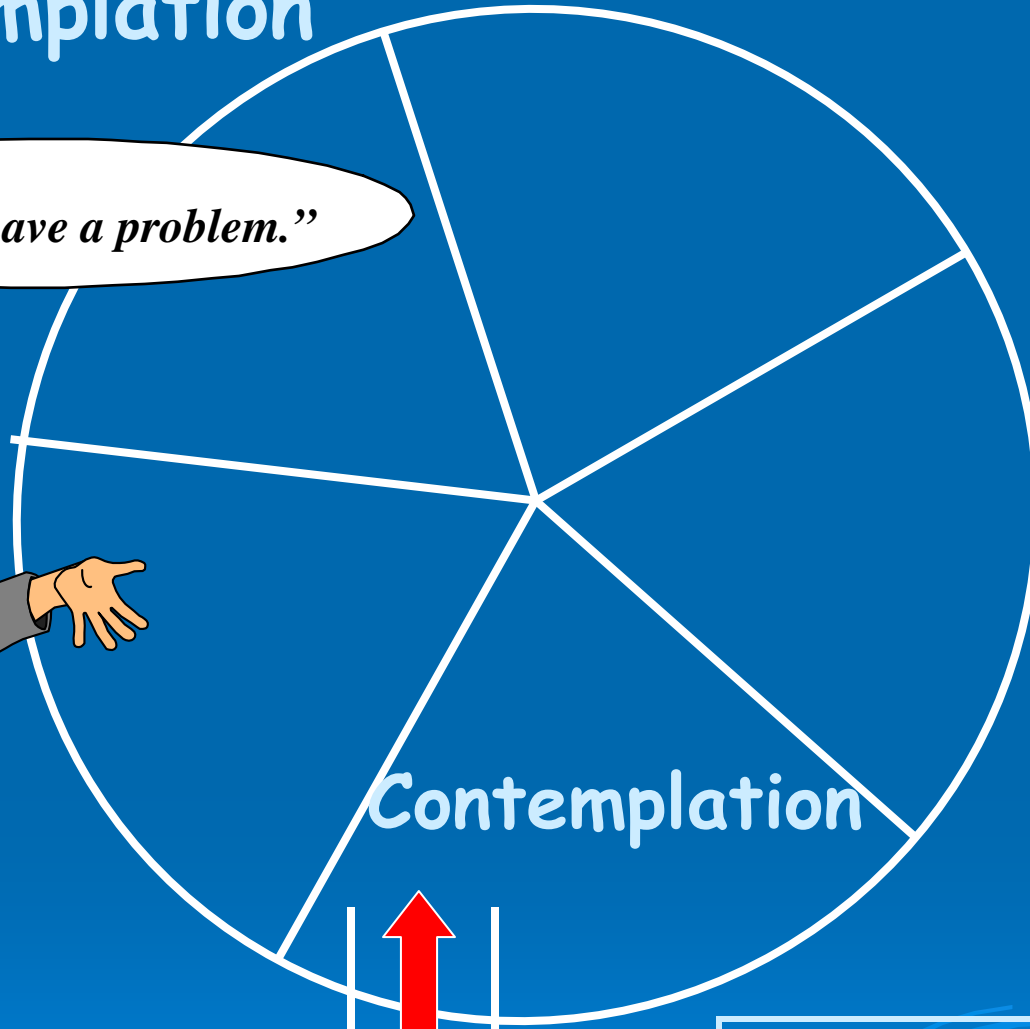
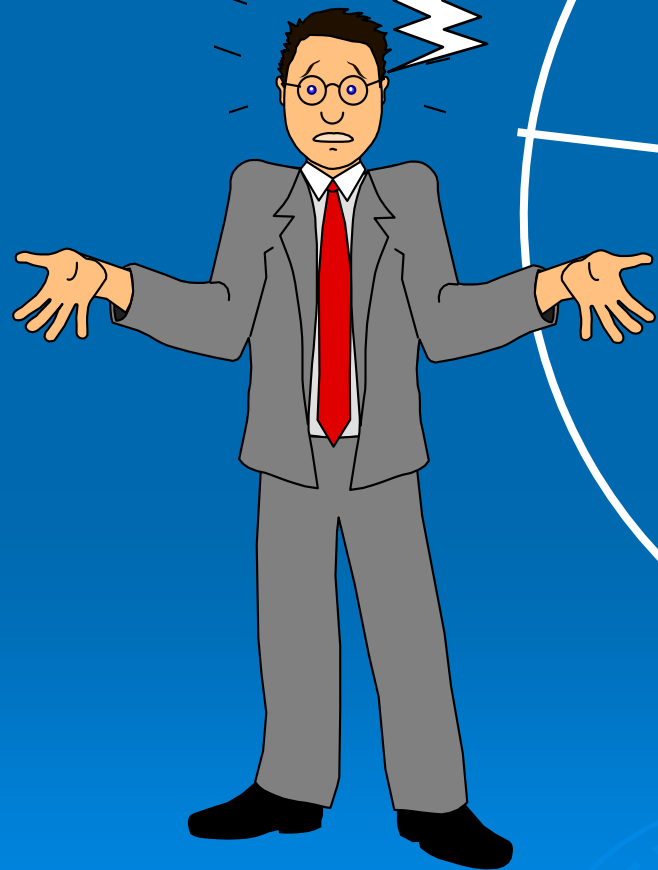
Adapted from Prochaska & DiClemente (1982), "Transtheoretical therapy: Toward a more integrative model of change," *Psychotherapy: Theory, Research, and Practice*, 19, 296-304.

# Pre-Contemplation



# Contemplation

*"Maybe I have a problem."*



**Pre-Contemplation**

Is thinking about  
changing a behavior

# Preparation

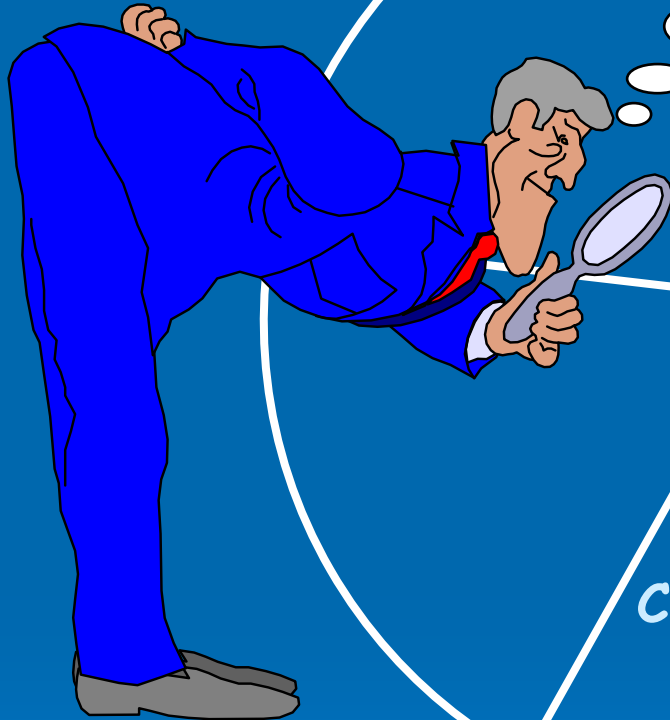
*"I've got to do something."*

Preparation

Contemplation

**Pre-Contemplation**

Is planning to  
change & has  
taken steps  
toward change.



Action

Action

*"I'm ready to start."*

Preparation

Contemplation

Actively taking  
steps to change

Pre-Contemplation



# Maintenance

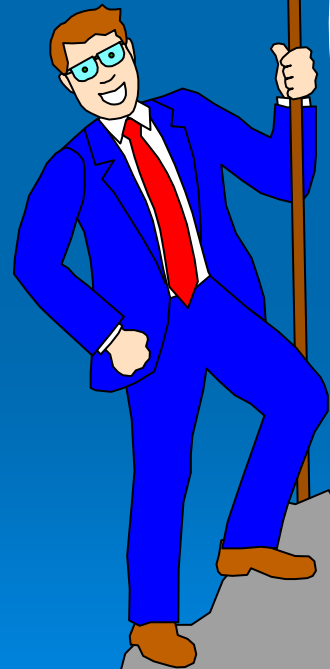
Action

Preparation

Contemplation

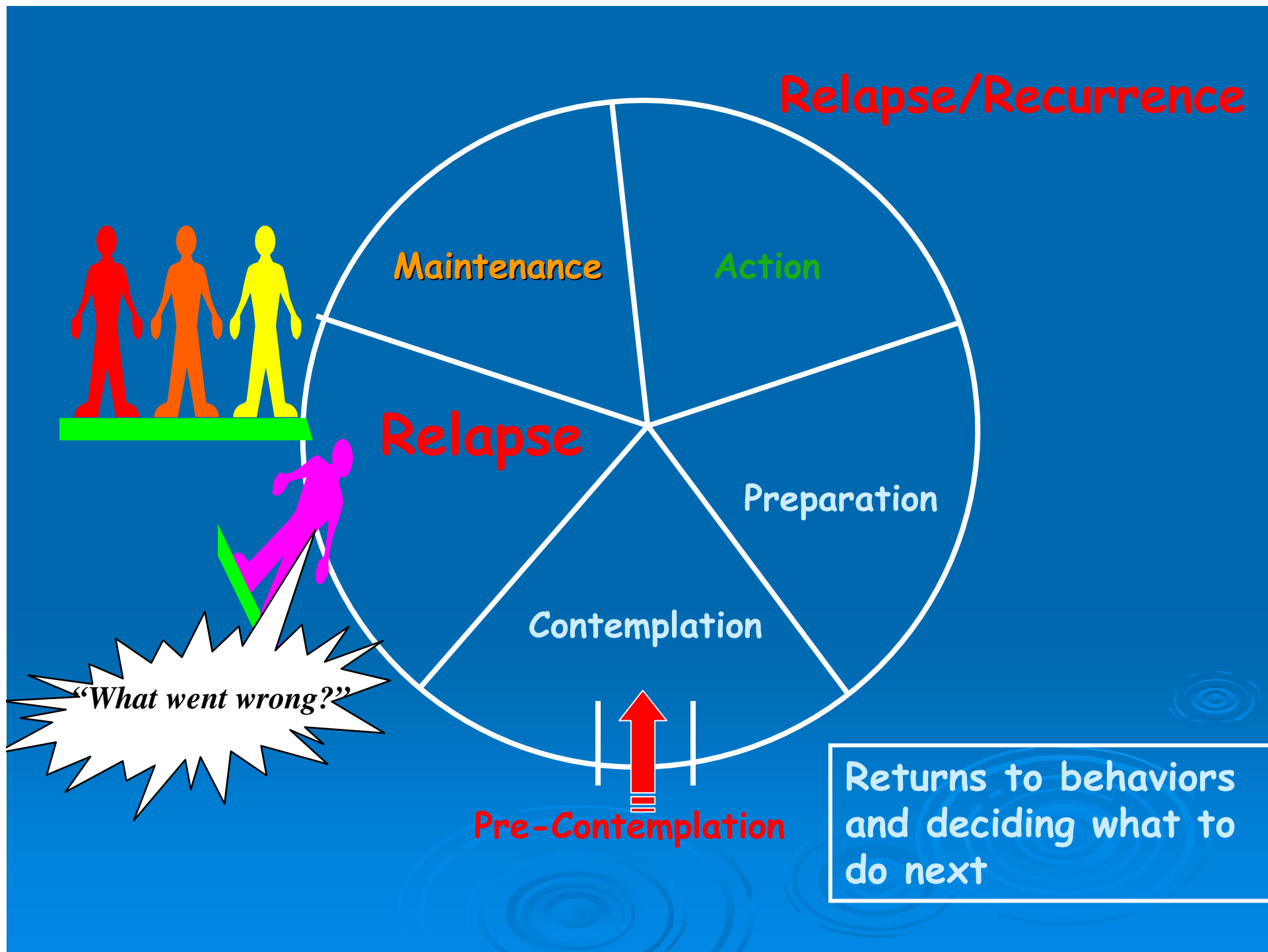
Maintenance

"How do I  
keep going?"



Pre- Contemplation

Achieved initial  
goals and is  
working to  
maintain gains



# Principles - Stages of Treatment

- Precontemplation - Engagement
  - Outreach, practical help, crisis intervention, develop alliance, assessment
- Contemplation/Preparation - Persuasion
  - What are the consumer's goals? What matters to them? Education, build awareness of problem, family support, peer support, Tip Ambivalence
- Active Treatment
  - Substance abuse counseling, medication treatments, social skills training, living skills training, leisure skills training, community reinforcement, self help groups
- Relapse prevention
  - Continue skills building in active treatment, expand recovery to other areas of life

# Stages of Change and Treatment

- Pre-contemplation
  - Contemplation and Preparation
  - Action
  - Maintenance
- Engagement
- > Persuasion
- Active Treatment
- Relapse Prevention

# Program implementation: 15 years in several states

- 60% of programs attain successful implementation
- High fidelity to model leads to good outcomes
- Without focus, fidelity erodes over time

# The Basic Change Paradigm

- Why change?
  - What is in it for me as a stakeholder?
- How to change?
  - How is the practice implemented?
- How to sustain the practice?
  - What structures need to be modified?



How many times do we hear these reactions to change?  
There are numerous reasons not to change.  
And one overpowering reason to change.  
**To improve the lives of adults with severe mental illness.**  
Evidence-Based Practices, worth the change.

# IDDT

## Guiding Treatment Principles

### 1. Integration of substance abuse & mental health treatments

- ← same clinicians
- ← same program or agency
- ← at the same time

# IDDT

## Guiding Treatment Principles

### 2. Flexibility & specialization of clinicians

← cross-trained staff

### 3. Assertive outreach

# **IDDT**

## **Guiding Treatment Principles**

### **4. Recognition of client preferences**

- ✓ client centeredness
- ✓ cultural competence

### **5. Close Monitoring**

### **6. Comprehensive Services**

# **IDDT**

## **Guiding Treatment Principles**

7. Range of Stable Living Situations

8. The Long-term Perspective

9. Stage-wise Treatment

10. Optimism



# Confrontation of Denial vs. Motivational Interviewing

- Heavy emphasis on acceptance of self as “alcoholic” or “addict”
- Acceptance of diagnosis is seen as necessary for change
- De-emphasis on labels
- Acceptance of label of “alcoholic” or “addict” is seen as unnecessary for change to occur

# Confrontation vs. Motivation

- Emphasis on disease of alcoholism or drug addiction which reduces personal choice and control
- Emphasis on personal choice regarding future use of alcohol and other drugs

# Confrontation vs. Motivation

- Therapist attempts to convince the client of the diagnosis by presenting “evidence” of alcoholism
- Therapist conducts objective evaluation but focuses on eliciting the client's own concerns and goals

# Confrontation vs. Motivation

- Resistance is seen as “denial”, a trait that is characteristic of alcoholics and/or addicts that requires confrontation
- Resistance is seen as an interpersonal behavior pattern that is influenced by the therapist’s behavior

# Confrontation vs. Motivation

- Resistance is met with argumentation and correction
  - Therapist takes responsibility for voicing the perspective, “You’re an addict, and you have to quit”
- Resistance is met with reflection
  - Therapist attempts to evoke from the client statements of the problem and a need for change: “Maybe this is more of a problem than I thought it was...”

# IDDT Fidelity Scale

## Part I: Treatment Characteristics

Factors for IDDT Service Delivery

14 Items

Definitions

Rationale

Data Source

## Part II: Organizational Characteristics

General Factors aimed at improving  
program's ability to implement any EBP

12 Items

Definitions

Rationale

Data Source

# Part I: Treatment Characteristics

## T1a: Multidisciplinary Team

### ➤ Definition

- Substance abuse specialist, case managers, psychiatrist, nurse, counselors, and other ancillary providers *work collaboratively* on the team with *evidence of excellent communication*

# T1b: Integrated SA Specialist

## ➤ Definition

- Substance abuse specialist with at least 2 years experience works collaboratively with team

# T2: Stage-Wise Interventions

## ➤ Definition

- All interventions (including ancillary) are consistent with and determined by client's stage of treatment/recovery

# T3: Access to Comprehensive DD Services

## ➤ Definition

- Consumers have access to comprehensive range of services [full range of residential, supported (competitive) employment, family psychoeducation, ACT (15:1, 24 hr care; 50% in community), illness management]; ancillary services are consistent with IDDT philosophy

# T4: Time-Unlimited Services

## ➤ Definition

- Clients with DD are treated on a time unlimited basis with intensity modified according to need

# T5: Outreach

## ➤ Definition

- All clients (esp. engagement stage) provided with assertive outreach (practical assistance in natural living environments)

# T6:Motivational Interventions

## ➤ Definition

- All practitioners understand and base interventions on motivational approaches

# T7: Substance Abuse Counseling

## ➤ Definition

- practitioners demonstrate understanding of basic substance abuse principles and provide to clients in active treatment and relapse prevention stages

# T8: Group DD Treatment

## ➤ Definition

- All clients are offered integrated group treatment and 2/3 regularly attend

# T9: Family DD Treatment

## ➤ Definition

- practitioners always attempt to involve family/ support network to give DD psychoeducation and promote collaboration with treatment team

# T10: Self-Help Participation

## ➤ Definition

- practitioners connect clients in active treatment or relapse prevention stages with substance abuse self-help programs



# T11: Pharmacological Treatment

## ➤ Definition

- Prescribers are trained in DD treatment; derive input from client and team to increase appropriate medication adherence; no medication prohibition; offer medication known to decrease use; avoid addictive meds

# T12: Interventions to Promote Health

## ➤ Definition

- Clients receive a comprehensive, structured, basic education on how to promote health; all staff are well-versed in such techniques

# T13: Secondary Interventions

## - SA Treatment Non-Responders

### ➤ Definition

- Program utilizes a specific plan to identify, evaluate, and link non-responders to more intensive interventions (e.g., supervised housing, payeeship, changing meds, etc.)

# Co-occurring Disorders: ...

## IDDT is a Recovery Model

- Goals are driven by consumer preference
- Services are provided with unconditional respect and compassion
- Practice provider shares responsibility for helping consumer with motivation for recovery
- Practice focuses on consumer goals and improving consumer's functioning
- Consumer choice and shared decision making are important

# Training

*Participants often cited training – at all levels - as the most critical factor in building programs and systems of care.*

Strategies for Developing Treatment Programs for People With Co-Occurring Substance Abuse and Mental Disorders. 2003. U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), p. 10.

[www.nccbh.org/cooccurringreport.pdf](http://www.nccbh.org/cooccurringreport.pdf)



“We now have thousands of experiments across the country which have proven that in mental health, training is not enough to create change.”

--Bob Drake

# Training As Usual

- “It may be a waste of time, energy, and financial resources to continue to train staff in this manner without first addressing the changes that are necessary in the systems within which they work to enable them to implement these interventions.”

- (Fadden, 1997)

# Appropriate Training

- Comprehensive Training Programs
  - Experimental & experiential learning
  - Live supervision
  - Attention to work environment
  - Staff support
  - Attention to removing barriers to use the newly implemented practice

# IDDT Training - Content

1. Research & efficacy of IDDT
2. Issues in the professional relationship
3. Stage-wise treatment model
4. Motivational Interviewing  
⇒ Basic and advanced skills
5. Engagement skills

# Training - Content

## 6. Assessment

⇒ functional and integrated

## 7. Treatment Planning

⇒ stage related interventions

## 8. Active Treatment

⇒ substance (ab)use & mental health

## 9. Group treatment

⇒ Principles, stages, skills, types

⇒ Basic & advanced

# Training - Content

10. Medical & health issues

11. Drugs of abuse

12. Family treatment interventions

13. Relapse prevention

14. Supervision

⇒ client-centered, outcomes based

# What We Are Learning...

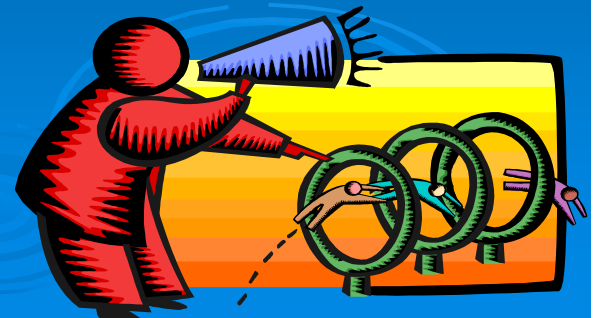
- Every program is in a budget crisis
- Every program has staff shortages
- Every program has resource problems
  - Transportation
  - Economy
  - Community partners
- Every program is uniquely “different”
- Every agency has the “most impaired clients”

# What We Are Learning From Agencies

- Directors and program leaders often believe services have higher fidelity than in actuality
- A significant disconnect between what administrators describe for services and what is provided to consumers
- CMHCs tend to cite lack of cooperative Mental Health Authorities as a major reason for not implementing EBPs

# What We Are Learning From Agencies

- Many treatment decisions are made based on personal biases
- Implementing one EBP makes it easier to implement other EBPs
- Agencies have discovered several positive benefits by combining EBPs




# Systems Issues

- How to integrate treatments?
- Stages of implementation: motivating, enacting, and sustaining
  - Each stage 1 year
- Changes at 5 levels
  - (1) Health authority
  - (2) Program leadership
  - (3) Clinician/supervisor
  - (4) Family
  - (5) Consumer

# Strategies for policy makers

- Building consensus for the vision of integrated dual disorder services
- Conjoint planning
- Define standards
- Structural, regulatory, reimbursement, and contracting mechanisms
- Demonstrations
- Training and monitoring

# Strategies for program leadership

- Consensus and vision
  - Specific leader
  - Train all clinicians
  - Comprehensive integration
  - Records
  - Outcomes
  - Quality assurance
- 

# Strategies for clinicians and supervisors

- Outcome based supervision
- Knowledge base
- New skills
  - Assessment
  - Motivational treatment
  - Substance abuse counseling
- Specialty training
- Secondary strategies

# Strategies for families/supports

- Information
- Support
- Collaboration
- Skills and reinforcement
- Advocacy and involvement

# Strategies for consumers

- Information
- Peer discussion
- Counseling
- Rehabilitation
- Training
- New roles - life is more persuasive than research

# Summary

- People recovering from serious mental illness and co-occurring substance abuse disorders can and do recover
- What remains to be seen is whether the systems of care serving those with co-occurring disorders can and do recover

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